EXHIBIT #55G

Applicant: LARRY A BOSS SS#: XXX-XX-8320

Are there any serious limitations with the ability to perform tasks on a sustained basis (an average day/week) without undue interruptions or distractions? ☒ Yes ☐ No

If YES, please explain FIXED IDEA STROKE PRONE PRECLUDES EMPLOYMENT.

10. **REMARKS**

Please describe any other impairments are conditions not covered by this form. THIS MAN IS AN UNFORTUNATE CONSEQUENCE OF WORK DISCRIMINATION OVER THE YEARS AND STROKE + SYNCOPAL EPISODES THAT HE NOW ASSOCIATES (FIXED IDEA) WITH WORK.

This state agency is requesting disclosure of information that is necessary to accomplish the statutory purpose as outlined under 20 CFR 404.1601 et. seq. Disclosure of this information is VOLUNTARY. This form has been approved by the State Forms Management Center.

Robert A. Fajardo, MD. 4/28/11 (312)922-6071

(Physician's signature and title) (Date) (Telephone Number)

122 SO. MICHIGAN AVE. #1413 CHICAGO, IL 60603

(Street Address) (City) (State) Zip Code)

112832602 4

Claim #: S69425
DF-104 (1/13/09)

E:12-129
IL 488-0459

MENTAL RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To: Re: Larry Boss (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) MY COPY

SSN:

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes and test results* as appropriate.

1. Frequency and length of contact: 1ST SEEN 1/14/10, THEN 1X/WEEK (45" SESSIONS) FOR 5-6 MONTHS. BREAK UNTIL LATE FALL, 2010. RETURN, SEEN 1X/W UNTIL MARCH, '[illegible]; THEN 1X/MONTH.

2. DSM-IV Multiaxial Evaluation:

   Axis I: 300.21 Axis IV: OCCUPATIONAL PROBS

   Axis II: 301.20 Axis V: Current GAF: 58

   Axis III: DIABETES MELLITUS Highest GAF Past year: 58

3. Treatment and response: PERIODIC, 45" SESSIONS, INDIVIDUAL MEDICAL PSYCHOTHERAPY. HAS CALMED; CAN TELL HIS STORY WITHOUT GETTING CRANKED TO ANGRY STATE

4. a. List of prescribed medications:

   INJECTABLE INSULIN

   b. Describe any side effects of medications that may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

   ——

5. Describe the *clinical findings* including results of mental status examination that demonstrate the severity of your patient's mental impairment and symptoms:

   ACCENTUATION + AGITATION TO SPEECH + EMOTIONAL STATE AS DESCRIBES DISCRIMINATION/OPPRESSION EXPERIENCED AT WORK, ANYONE. NOT A THOUGHT DISORDER. BECOMES FEARFUL OF HAVING A STROKE AND DEATH.

6. Prognosis: POOR FOR RETURNING TO PRESENT JOB. HE CAN'T DO IT! EXPERIENCES EXTREMES OF ANGER AT IMPROPER MISUSE OF [illegible]

7. Identify your patient's signs and symptoms:

	Anhedonia or pervasive loss of interest in almost all activities		Intense and unstable interpersonal relationships and impulsive and damaging behavior
	Appetite disturbance with weight change		Disorientation to time and place
X	Decreased energy		Perceptual or thinking disturbances
	Thoughts of suicide		Hallucinations or delusions
	Blunt, flat or inappropriate affect		Hyperactivity
	Feelings of guilt or worthlessness		Motor tension
	Impairment in impulse control		Catatonic or other grossly disorganized behavior
	Poverty of content of speech	X	Emotional lability
X	Generalized persistent anxiety		Flight of ideas
	Somatization unexplained by organic disturbance		Manic syndrome
X	Mood disturbance		Deeply ingrained, maladaptive patterns of behavior
X	Difficulty thinking or concentrating AT WORK		Inflated self-esteem
X	Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress	X	Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury
	Psychomotor agitation or retardation		Loosening of associations
	Pathological dependence, passivity or agressivity		Illogical thinking
	Persistent disturbances of mood or affect		Vigilance and scanning
	Persistent nonorganic disturbance of vision, speech, hearing, use of a limb, movement and its control, or sensation		Pathologically inappropriate suspiciousness or hostility
	Change in personality		Pressures of speech
X	Apprehensive expectation		Easy distractibility
?	Paranoid thinking or inappropriate suspiciousness		Autonomic hyperactivity
	Recurrent obsessions or compulsions which are a source of marked distress		Memory impairment – short, intermediate or long term
	Seclusiveness or autistic thinking		Sleep disturbance
	Substance dependence		Oddities of thought, perception, speech or behavior
	Incoherence		Decreased need for sleep
X	Emotional withdrawal or isolation		Loss of intellectual ability of 15 IQ points or more
	Psychological or behavioral abnormalities associated with a dysfunction of the brain with a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities		Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror and sense of impending doom occurring on the average of at least once a week
	Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)		A history of multiple physical symptoms (for which there are no organic findings) of several years duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly
	Persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity or situation	X	Involvement in activities that have a high probability of painful consequences which are not recognized

8. To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting,* please give us your opinion **based on your examination** of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

- *Seriously limited, but not precluded* means ability to function in this area is seriously limited and less than satisfactory, but not precluded in all circumstances.
- *Unable to meet competitive standards* means your patient cannot satisfactorily perform this activity independently, appropriately, effectively and on a sustained basis in a regular work setting.
- *No useful ability to function,* an extreme limitation, means your patient cannot perform this activity in a regular work setting.

I.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK	Unlimited or Very Good	Limited but satisfactory	**Seriously limited, but not precluded**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Remember work-like procedures		X			
B.	Understand and remember very short and simple instructions		X			
C.	Carry out very short and simple instructions		X			
D.	Maintain attention for two hour segment		X			
E.	Maintain regular attendance and be punctual within customary, usually strict tolerances	X				
F.	Sustain an ordinary routine without special supervision	X				
G.	Work in coordination with or proximity to others without being unduly distracted				X	
H.	Make simple work-related decisions			X		
I.	Complete a normal workday and workweek without interruptions from psychologically based symptoms				X	
J.	Perform at a consistent pace without an unreasonable number and length of rest periods				X	
K.	Ask simple questions or request assistance		X			
L.	Accept instructions and respond appropriately to criticism from supervisors			X		
M.	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes	X				
N.	Respond appropriately to changes in a routine work setting				X	
O.	Deal with normal work stress				X	
P.	Be aware of normal hazards and take appropriate precautions	X				

(Q) Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

II.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	Unlimited or Very Good	Limited but satisfactory	**Seriously limited, but not precluded**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Understand and remember detailed instructions		X			
B.	Carry out detailed instructions				X	
C.	Set realistic goals or make plans independently of others	X				
D.	Deal with stress of semiskilled and skilled work				X	

(E) Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

III.	MENTAL ABILITIES AND APTITUDE NEEDED TO DO PARTICULAR TYPES OF JOBS	Unlimited or Very Good	Limited but satisfactory	**Seriously limited, but not precluded**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Interact appropriately with the general public	X				
B.	Maintain socially appropriate behavior	X				
C.	Adhere to basic standards of neatness and cleanliness	X				
D.	Travel in unfamiliar place		X			
E.	Use public transportation	X				

(F) Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

BECOMES SO ANGRY AT FEELING DISCRIMINATED AGAINST + AT FEELING HE'S GIVEN INAPPROPRIATE ASSIGNMENTS. HE DEVELOPS PANICKY STATE + SYNCOPAL EPISODES AND BECOMES FEARFUL HE'LL HAVE STROKE + DIE.

9. Does your patient have a low IQ or reduced intellectual functioning?
¨ Yes (No) [circled]

Please explain (with reference to specific test results):

____

____

10. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom?
¨ Yes (No) [circled]

If yes, please explain: ______________________________

____

11. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

¨ Never
¨ About one day per month
¨ About two days per month
¨ About three days per month
¨ About four days per month
¨ More than four days per month

12. Has your patient's impairment lasted or can it be expected to last at least twelve months?
¨ Yes ¨ No

13. Is your patient a malingerer? ¨ Yes ¨ No

14. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation? ¨ Yes ¨ No

If no, please explain: ______________________________

15. Please describe any additional reasons not covered above why your patient would have difficulty working at a regular job on a sustained basis.
CANNOT WORK AT THIS PLACE WHERE HE FEELS DISCRIMINATED AGAINST.

16. If your patient's impairments include alcohol or substance abuse, do alcohol or substance abuse contribute to any of your patient's limitations set forth above?
¨ Yes ¨ No

If Yes, a) please list the limitations affected:

b) please explain what changes you would make to your description of your patient's limitations if your patient were totally abstinent from alcohol or substance abuse:

17. Can your patient manage benefits in his or her own best interest? ¨ Yes ¨ No

18. What is the earliest date that the above description of limitations applies? JANUARY, '11

7/27/11
Date

Robert A. Fajardo, M.D.
Signature

Printed/Typed Name: ROBERT A. FAJARDO, M.D., S.C.

Address: 122 SO. MICHIGAN AVE. SUITE #1413 CHICAGO, IL 60603

7-66a 2/04

Claimant has INVOICE – RETURN FOR PAYMENT

We pay $20 for the medical evidence. Please assure that all identifying information listed below is correct. Payment will be made as follows unless corrected. This form must be attached to the medical evidence.

- FEIN must be registered with Illinois State Comptroller using Form W-9, available at www.irs.gov. Fax a copy of this invoice page with the completed Form W-9 to 217-524-9177.
- Requests made to physicians affiliated with a facility need the facility provider's name.
- This form (invoice) must be completed each time payment is requested.
- For questions regarding this payment, contact 217-782-4374. Your invoice number is: *L1099847*

SSN/FEIN: 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
Name: Robert A Fajardo MD
Address: Robert A Fajardo MD SC
122 S Michigan Ave Ste 1413
Chicago IL 60603

Telephone No. (312) 922-6071

[signature]
Provider's Signature

CORRECTIONS MUST BE MADE BELOW IN ORDER TO RECEIVE PAYMENT

Mailing Address for Medical Records: *(Only if different from address where patients are seen)*	FEIN: NPI *(Individual)*: 1275617383 NPI *(Facility)*:
Payment Address: *(Only if different from mailing address)*	Name: Title: *(MD, DO, Psy D, LCSW, etc.)*
Facility Name & Physical Address: *(Patients are seen at this location)*	Main Phone: Medical Record Phone: Medical Record Fax:
Copy Service Name(s) & FEIN(s):	

FOR OFFICE USE ONLY

RR, P_____ RR, NO P_____ NO RR, NO P_____ 01045 (X) DI (30) $20.00

1131245271
T31683

RE: LARRY A BOSS
ENCS: 827/env.
L28

E:12-235
(1/30/09)
IL:488-0603

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)
ROBERT A. FAJARDO, M.D.

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☒ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ ______

☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)
122 So. Michigan Ave. #1413

Requester's name and address (optional)

City, state, and ZIP code
Chicago, IL 60603

List account number(s) here (optional)

Part I **Taxpayer Identification Number (TIN)**

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number
☐☐☐ - ☐☐ - ☐☐☐☐

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Employer identification number
36 - 3245721

Part II **Certification**

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Robert A. Fajardo, MD Date ▶ 8/11/11

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

ILLINOIS DEPARTMENT OF HUMAN SERVICES
DIV OF REHAB SERVICES, DISABILITY DETERMINATION
P.O. Box 19250 • Springfield, Illinois 62794-9250
Michelle R. B. Saddler, Secretary • Ann P. Robert, Deputy Director

July 28, 2011

Robert A Fajardo MD SC
122 S Michigan Ave Ste 1413
Chicago IL 60603

REQUEST FOR MEDICAL EVIDENCE

Fax your report to 1-866-778-4959.

******THIS PAGE MUST BE THE COVER PAGE OF YOUR FAX/REPORT.******

OR

For information about sending reports to our free, secure website, email:

CH.IL.S16B.ERE@SSA.GOV

Or mail your report to this address:

FIRST-CLASS MAIL PERMIT NO. 99181 WASHINGTON, DC
POSTAGE WILL BE PAID BY ADDRESSEE

SSA
S16 Springfield, IL
P.O. Box 8701
London, KY 40742-9800

RQID:1131245271T31683 SITE:S16 DR:S
SSN:********* DOCTYPE:0001 RF:D CS:57eb

1131245271
T31683

RE: LARRY A BOSS
ENCS: 827/env.
L28

E:12-235
(1/30/09)
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